

The Domestic Violence Coalition of Greater Chattanooga, Inc.

Charlotte B. Boatwright, Ph.D., Chair
1106 Carter Drive, Chattanooga TN, 37415
(423)875-0120 Fax (423) 875-9768 E-mail: DVCCOM@aol.com

Sample Domestic Violence Intervention Protocol for Health Care Providers

I. Introduction

The Domestic Violence Coalition of Greater Chattanooga, Inc. is inspired by respect for the individual and the wish to empower persons with knowledge to make decisions about very personal situations. Our mission is to reduce violence in the community which includes Hamilton and surrounding Tennessee counties as well as those Northwest Georgia and Northeast Alabama. As a coordinated community group we:

- Promote prevention, early intervention and education to reduce violence in the community
- Coordinate services among agencies, departments and the courts in order to improve community response to family violence
- Inform elected officials about issues pertaining to family violence

Health care providers serve at significant points for triage, incur considerable costs and bear considerable responsibility as members of a coordinated community response to reduce family violence.

The annual cost for domestic violence as estimated by die American Bar Association is in excess of \$67 billion. The health care dollar cost for family violence exceeds \$10 billion. That amount bears no comparison to the cost of human incapacitation and suffering to victims, including children who are often caught in the misery of combat in the home.

As a critical segment of the network of community agencies who must address family violence issues, providers can identify, treat, document and refer victims of violence to other appropriate community agencies for the services they need.

The following protocol provides guidelines to assist health care professionals in meeting those needs.

II. Definition

Legal: According to Tennessee law, domestic assault has occurred when a family or household member causes or attempts to cause bodily injury to another family or household member. Legal definition of family or household member includes people living as spouses, people related by blood or marriage, people who have a child in common, people whose sexual relationship has resulted in a current pregnancy, people jointly residing in the same dwelling unit who are aged 18 years or older or who are emancipated and people who have or have had a dating relationship.

Behavioral: Behaviorally, family violence encompasses a much broader scope and includes violence occurring within the context of intimate relationship and includes spousal abuse, intimate partner abuse, elder and child abuse, dating violence and sexual assault or rape.

III. Guidelines for Intervention

Though 95 percent of reported cases of domestic violence involve that of males against females, it is not a gender issue and can occur as female to male or between same sexes. For the sake of brevity, victims are referred to as women in these protocols.

Domestic or family violence flourishes in an atmosphere of silence and isolation, so many victims will have great difficulty admitting that they have been injured by a family member and discussing this information. Providers must respect the decision of the victim, but can impart information about available resources with statements such as, "Should you find yourself or a friend in an unsafe situation, you may want to know..." Written materials should be made available to the victim, but she should not be asked to take them with her unless she elects to do so.

- Make credit card size or one-page safety plans available in your restrooms.
- Place posters with hotline numbers on them in restrooms so that patients can write them in an inconspicuous place.

SCREENING:

Family abuse may occur on a continuum from emotional abuse and verbal assault to severe physical assault. Each form of abuse is significant and places the victim at risk of injury - emotion and physical - including death.

- Every woman seeking care should be asked directly if anyone has ever physically or psychologically hurt her. Denial is a potent defense for both victim and perpetrator, so the victim may not be able to make the connection between certain behaviors and abuse, (i.e., pinching, pushing, etc.)

SCREEN WOMEN CAREFULLY WHO PRESENT WITH THE FOLLOWING PROBLEMS:

- **LIMITED ACCESS TO MEDICAL CARE:**
 - abuser may control or deny access to care, money, transportation, use of phone, etc.
 - failure to keep appointments or leaving before being seen after arriving for appointment
 - failure to purchase or take prescribed medication or show up for scheduled procedures
 - homelessness may prevent access to care and increase likelihood of victimization
 - partner insists on accompanying victim in health care setting, overly solicitous of victim's health
 - partner answers provider's questions directed to patient; patient too intimidated to answer/speak
 - partner waits outside door when asked to leave (try to overhear what is being said)
 - partner attempts to intimidate victim or provider, demands that victim leave before exam/procedure complete
 - partner voices or displays signs of jealousy of victim in relationship to provider
 - some abusers become threatening, others are very charming, thoughtful, concerned
- **PHYSICAL SIGNS:**
 - injuries to face, neck, arms, torso, breasts or genitals
 - contusions, abrasions, burns, lacerations, gun and puncture wounds
 - rib fractures, missing teeth, broken jaw, perforated ear drum, hematuria, back injuries
 - chest pain, fatigue, sexual dysfunction, UTI's
 - bilateral distribution or injury to multiple areas
 - multiple injuries in various stages of healing
 - evidence of rape or sexual assault, unplanned pregnancies, abortions, premature births, STD, HTV infections

- pregnant women with vaginal bleeding, spontaneous abortion, abruptio placenta and general poor self-care
- inappropriate or inadequate dress for weather condition
- **PSYCHOLOGICAL SYMPTOMS:**
 - repeated visits to emergency rooms
 - delay between time of injury or onset of disease and arrival for medical care
 - explanation by victim or partner that is inconsistent with type or severity of injury
 - vague, non-specific or multiple migrating complaints
 - PTSD, psychological symptoms (anxiety, depression, sleep or digestive disorders, suicidal ideation panic attack)
 - hesitant/incomplete reporting of medical history; incoherent or chaotic reporting, chronology of reporting does not match symptomatology
- **INTERVENTION:** (See attachment from Massachusetts Medical Society)
 - R-Routinely Screen Female Patients
 - A-Ask Direct Questions
 - D-Document your findings
 - A-Assess Patient Safety
 - R- Review Option/Referral
 - ALWAYS, ALWAYS, ALWAYS, review the medical record
 - establish an atmosphere for privacy, developing trust, concern and willingness to discuss abuse
 - treat medical/mental health problems
 - provide SAFETY PLAN and plan for follow-up care
 - confidentiality essential; the patient's life could depend upon it

RADAR: A DOMESTIC VIOLENCE INTERVIEW (Developed by Massachusetts Medical Society)

R = ROUTINELY SCREEN FEMALE PATIENTS

Although many women who are victims of domestic violence will not volunteer any information, they will discuss it if asked simple direct questions in a non-judgmental way and in a confidential setting. *Interview the patient alone.*

A = ASK DIRECT QUESTIONS

"Because violence is so common in many women's lives, I've begun to ask about it routinely":

"Are you in a relationship in which you have been physically hurt or threatened?"¹ If no, "Have you ever been?"

"Have you ever been hit, kicked or punched by your partner?"

"I notice you have a number of bruises; did someone do this to you?"

D = DOCUMENT YOUR FINDINGS

Record a description of the abuse as she has described it to you. Use statements such as "the patient states she was..."¹ If she gives the specific name of the assailant, use it in your record. 'She says her boyfriend John Smith struck her...' Record all pertinent physical findings. Use a body map to supplement the written record. Offer to photograph injuries. When serious injury or sexual abuse is detected, preserve all physical evidence. Document an opinion if the injuries were inconsistent with the patient's explanation.

A = ASSESS PATIENT SAFETY

Before she leaves the medical setting, find out if she is afraid to go home. Has there been an increase in frequency or severity of violence? Have there been threats of homicide or suicide? Have there been threats to her children? Is there a gun present?

R = REVIEW OPTIONS & REFERRALS

If the patient is in imminent danger, find out if there is someone with whom she can stay. Does she need immediate access to a shelter? Offer her the opportunity of a private phone to make a call. If she does not need immediate assistance, offer information

about hotlines and resources in her community. Remember that it may be dangerous for the woman to have these in her possession. Do not insist that she take them with her. *Make a follow up appointment to see her.*

IF THE PATIENT ANSWERS YES:

Encourage her to talk about it

'Would you like to talk about what has happened to you? 'How do you feel about it?' "What would you like to do about this?"

Listen non-judgmentally.

This serves both to begin the healing process for the woman and to give you an idea of what kind of referrals she may need.

Validate her experience.

"You are not alone." "No one has to live with violence." "You do not deserve to be treated this way." "You are not to blame." "What happened to you is a crime." "Help is available to you."

IF THE PATIENT ANSWERS NO, OR WILL NOT DISCUSS THE TOPIC:

Be aware of tiny clinical signs that may indicate abuse: injury to the head, neck, torso, breasts, abdomen or genitals; bilateral or multiple injuries; delay between onset of injury and seeking treatment; explanation by the patient which is inconsistent with the type of injury; any injury during pregnancy, especially to abdomen or breasts; prior history of trauma; chronic pain symptoms for which no etiology is apparent; psychological distress such as depression, suicidal ideation, anxiety and/or sleep disorders; a partner who seems overly protective or who will not leave the woman's side.

If any of these clinical signs are present, ask more specific questions. Make sure she is alone. "It looks as though someone may have hurt you. Can you tell me how it happened?" "Sometimes when people feel the way you do, it may be because they are being hurt at home. Is this happening to you?"

If the patient denies abuse, but you strongly suspect it, document your opinion, and let her know there are resources available to her should she choose to pursue such option— in the future. Make a follow up appointment 10 see her.

Source: Improving the Health Care System's Response to Domestic Violence.

INTERVIEWING PATIENTS:

- Suggestions for interview process/questions (See check list - Are You Abused?)

I routinely ask patients about their personal relationships

Has anyone close to you recently or ever hurt you physically? emotionally? sexually?

Has your partner ever hit you?

Have you ever had medical treatment for injuries made by your partner?

If you could change two things about your partner, what would you change?

Has your partner ever scared you? What happened? Are you ever afraid of your partner?

What does your partner act like when he/she has been drinking? Using drugs?

During your relationship, have there been times when an argument has become physical?

How do you and your partner resolve arguments?

Is jealousy and issue with you and your partner? Does your partner ever call you names or put you down?

Does your partner ever try to control what you do?

Does your partner ever lose his temper? Throw things? What happens when your partner loses his temper? Do you ever get scared?

Has your partner ever forced you to have sex when you did not wish to?

Have you ever been hit, slapped or kicked while you were pregnant? Has the abuse increased since you are pregnant?

Remembering the last time you were abused, mark the places on the body diagram where you were hurt.

Are your children affected by your partner's behavior? Have they ever seen him/her abuse you? What do your children say to you about the abuse?

Do you know where you could go if you were abused or worried about abuse?

*Adapted from a list by Amiee Luwis O'Coimor, MS, MIML, KN

- **DOCUMENTATION:**

- Obtain a complete history of abuse, reporting:
 - victim's report of specifics of presenting condition (use verbatim descriptions when possible)
 - date, time, location of all reported physical or verbal assaults
 - victim's relationship to abuser
 - mechanism of injury, use or threats of injury with weapons
 - previous trauma
 - relevant social history
- Document thorough physical examination:
 - use anatomical drawing to illustrate injury sites
 - use rape kit if appropriate. **BE SURE TO COMPLETE THE WHOLE KIT.**
- Record your objective, professional observations about consistency of findings with victim's report of injuries.
- Document evidence when police are called including names, badge numbers, action offered or taken.
- Document discharge plan and plan for follow-up care.
*** Include photographs of injuries with consent of victim. Ask her to return for pictures

- **REPORTING:**

*Tennessee does not have a mandatory reporting law, but physicians are requested to voluntarily report domestic violence injuries (T.C.A. 36-3-601). See Voluntary Domestic Violence Screening/Statistical Form for return to Tennessee Department of Health.

VI. THE IDENTIFIED BATTERED WOMAN

- If a patient self-identifies or discloses battering to you, provide her with extra time. She may desire to remain in a private area, especially if she is in a decision-making phase, attempting to decide whether to return to her male partner. If her male partner is in the waiting area, ask *her if she feels safe* at this time. Her options are:
 - a. immediate access to shelter
 - b. shelter information and access at later date
 - c. access to counseling
 - d. returning to the male partner, with follow-up appointment
 - e. referral to prosecutorial or police agencies, especially if injuries are apparent
- Use empathetic, active listening skills if a victim discusses a battering incident with you. Encourage discussion of immediate safety needs using questions like "Do you feel you are safe now with your partner?" or "Does your partner have a gun in the house or threaten you with a weapon?" or "Do you have plans for help if he hits you again?"

(It is generally thought that battered women evaluate their own safety or danger potential;

however the health care provider should encourage realistic discussions of the battering situation to encourage informed decision making?)

- Educate her about signs of escalating physical danger, which include: (see lethality assessment)
 - Availability or access to weapons
 - Assaults or threats with weapons
 - Extension of his assaults, or threats of assaults to children, pets or extended family members.
 - Surveillance of woman at work, increasing isolation of woman
 - Extreme jealousy, accusations of infidelity
 - Forced sexual encounters
 - Battering during pregnancy
 - Decrease or absence of remorse expressed by the batterer

- Particular attention should be paid to postpartum women experiencing emotional or physical abuse. Observe for extended postpartum 'blues' in the mother, feeding problems in the infant and poor communication between the couple. Be alert for postpartum women reporting coercive sexual patterns from male partners. Battered women report that sexual assault occurs during the postpartum period.

VII. SUMMARY OF PREVENTION OF BATTERING STRATEGIES FOR ALL WOMEN

- To empower all victims toward self care behavior remember:
 - Assess all female patients for battering.
 - Provide written referral information to community resources.
 - Assess for battering in a private location, away from partners and children
 - Use non-judgmental, empathetic responses when assessing for abuse.
 - Observe for signs suggestive of battering, such as
 - injuries inconsistent with explanation
 - vague or multiple physical complaints,
 - complaints of "problems with husband" or "problems at home"
 - crying, sighing, laughing at abuse assessment questions
 - no eye contact or searching, engaging eye contact when assessing for battering,
 - fear when discussing battering, or
 - ambivalent statements about battering.

- Document assessment, teaching, photographing, referrals, statements or threats from batterer.
 - Provide the battered woman with copies of her health record related to battering incident to facilitate filing charges with law enforcement or the courts.
 - Self care increases with information, positive reinforcement, shared health goals and decision making between provider and patient.
 - Sometimes, with all your efforts, a battered woman may continue to feel her only option is to remain with the batterer. However, your empathetic responses may assist her toward self-help and the referral information you give her may be utilized at a later date.
 - **Respect the victim's decision. She may be trying to stay alive as 75% of domestic homicides and serious injuries occur when the victim is trying to leave the abuser.**

VIII. PROVIDING PRACTICAL SUPPORT TO ABUSED WOMEN:

Patience is crucial. Many victims of violence have not talked about their abuse. Allow her to tell her story and express her feelings.

Let her know that she does not deserve to be treated this way. Even if she changes, the abuse will not.

Respect that values will differ from culture to culture. Individual values may affect how a victim behaves and the choices that will be made.

Let her know that help is available, and even though she may not be ready now, you will be there when she is ready.

Let her know that you are concerned for her safety and the safety of her children. Discuss with her the impact that violence has on children who witness violence and explore alternatives to safety.

Understand her ambivalence about leaving. Remember that making a change is a process and that many women are in greater danger when they leave. Trust her decisions and support her; giving her choices and letting her decide.

Recognize that many women feel embarrassed and ashamed about the abuse. Many women feel that have contributed to the abuse and that they are equally responsible. Work with the women to help dispel the myths.

Reinforce to her that she is not alone. The feeling of being alone makes her feel isolated.

Share with her the incidence and prevalence rate for domestic violence. Share with her (confidentially) information about other cases. Discuss the options of individual counseling and or victim's support groups.

Building a rapport and trusting relationship may entrust a victim to confide in you and work towards taking steps that keep her (and her children) safe and free of violence.

Keep in mind that victims living in violence possess amazing survival skills. Often when a crisis occurs, a victim may experience difficulty making decisions. Such difficulty is part of the post traumatic stress syndrome. A clinician's most effective support would be to discuss the choices available and support her choice.

Source: Adapted from writings by Annie LeMS O'Connor, MS, MPH, ItM, Conference of Boston Teaching Hospitals' Domestic Violence Task Force

IX. EMPOWERING RESPONSES

You do not deserve to be hit or injured. No one deserves to be treated badly by a partner. No matter what, it is not OK for your partner to hurt you. It is wrong and it is against the law.

You deserve to be treated decently. Violence and threats of violence that make you afraid are wrong.

I'm concerned for your safety. I'm concerned about the safety of your children. I'd like to talk to you about making a safety plan in case you need to leave quickly. (Go over safety plan or refer to someone who will do this.)

You may not want to do anything right now, but I would like to tell you about the services that are available. (Make a referral, give information and/or hot line number).

No matter what you decide to do, I am still your doctor and I want you to know that we will work together on all of your health problems and continue to talk at your appointments about how things are at home. If things get worse or you would like to talk to me again about this, please call me.

Many women are in violent relationships. It is a very common problem. You are the one who decides what to do

and when. I will support the decisions that you make, even though I will encourage you to consider all of your options.

Your medical record is confidential, and cannot be released without your written permission. You do need to know that I am required by state law to report any gunshot or knife wound, if you are seriously burned, or if children are being abused at home. If both you and the children are being hurt, it is possible to help all of you together.

Source: Eleanor Hobbs, MD, Conference of Boston Teaching Hospitals' Domestic Violence Task Force